71% had achieved SVR and 34% had advanced fibrosis/cirrhosis. 53% of patients had a diagnosis of depression. With the exception of the hepatitis specific limitations scale (HLIM), patients diagnosed with depression and those with a reduced level of physical activity scored significantly lower in all components of the HQLQv2 questionnaire (all $p<0.05$). The median physical functional component score was significantly lower in patients with advanced fibrosis/cirrhosis (38.6) compared to those without (47.4, $p=0.012$). Patients who achieved SVR scored significantly higher on the positive wellbeing score, HLIM, and the hepatitis specific health distress scale (HHD) compared to those with detectable HCV RNA ($p=0.035$, $p=0.029$ and $p=0.004$, respectively). Multivariable linear regression adjusted for age, gender, BMI and level of physical activity illustrated that both the presence of depression (aOR-19.85 95%CI -34.37—5.32, $p=0.008$) and achieving SVR (aOR 20.63 95%CI 4.02–37.24, $p=0.016$) were independently associated with the HHD score.

Conclusions Our data, from a real world setting, suggests that achieving SVR is associated with an improvement in QoL by reducing physical, mental and emotional limitations associated with HCV. Depression is also highly prevalent in this population and independently impacts upon patients QoL. This suggests the importance of utilising a holistic approach when assessing these patients.

P209 OVERLAP PRIMARY BILIARY CHOLANGITIS-AUTOIMMUNE HEPATITIS SYNDROME: SINGLE TERTIARY REFERRAL CENTRE EXPERIENCE

[1]Naw April Phaw*, [2]Michael Zhang, [1,3]David Jones, [1,3]Jessica Dyson. *[1]Liver Unit, Newcastle upon Tyne Hospitals NHS Foundation Trust, Newcastle upon Tyne, UK; [2]Newcastle University Medical School, UK; [3]Newcastle Biomedical Research Centre,Newcastle University, UK*

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Background and Aims Features of primary biliary cholangitis (PBC) and autoimmune hepatitis (AIH) coexist in some patients; termed PBC-AIH overlap syndrome. The Paris Criteria are used for diagnosis. Treatment is determined by the predominant disease and those with active inflammation may respond to immunosuppression. This study aimed to review the characteristics and treatment response to immunosuppression in PBC-AIH overlap patients.

Method All prevalent patients with a clinical diagnosis of PBC-AIH overlap between 2010 and 2018 at a single tertiary centre were retrospectively reviewed. Patients who met the Paris criteria were termed '**True Overlap**' and those who did not were classed '**Clinical Overlap**'. The 2 groups were reviewed for clinical course and treatment outcome.

Results There were 39/66 (59%) patients with True Overlap. Approximately 97% of patients were female in both groups. Median age at diagnosis was 55 and 56 years in the True and Clinical Overlap groups, respectively, with median ALT (144 vs 114,$p=0.07$) and ALP (175 vs 203,$p=0.37$) at presentation. 36% (14/39) of True Overlap patients had advanced disease at diagnosis or progressed to cirrhosis, compared to 18% (5/27) in Clinical Overlap. More patients with True Overlap had moderate-severe interface hepatitis on biopsy than Clinical Overlap (38 vs 18, $p= 0.001$) but there was no difference in the presence of florid bile duct lesions. Immunosuppressants improved ALT ($p<0.001$) in both groups. 61%(19/31) of True overlap patients on immunosuppression achieved biochemical remission(normal ALT and IgG) for the AIH component as compared to 52%(10/19) of Clinical Overlap. Severe interface hepatitis ($p<0.05$) at presentation and ductopenia ($p<0.001$) were associated with incomplete response to immunosuppression in both groups.

Conclusion In our unit, patients are treated clinically as having PBC-AIH overlap syndrome without having to meet the current Paris Criteria. Both groups had similar baseline biochemical characteristics with improvement in markers of inflammation with treatment but those with True Overlap had more severe inflammation and poorer clinical outcomes. Approximately half of the Clinical Overlap patients treated with immunosuppressant achieved biochemical remission despite not meeting Paris Criteria and 39% of True Overlap patients failed to achieve biochemical remission. This study suggests that the criteria for diagnosing overlap syndromes would benefit from refinement so that we can better delineate these disease phenotypes to ensure that patients who will benefit from immunosuppression get the appropriate therapy.

P210 ENHANCED-LIVER-FIBROSIS SCORE WAS NOT INFLUENCED BY ALCOHOL CONSUMPTION IN A PATIENT COHORT WITH ALCOHOL-USE-DISORDERS

[1,2]Freya Rhodes*, [1,2]Sara Cococcia, [3]Declan Connoley, [1]Preya Patel, [1,2]William Rosenberg. *[1]Institute for Liver and Digestive Health, UCL, London, UK; [2]Department of Hepatology, The Royal Free London NHS Foundation Trust, London, UK; [3]Faculty of Medicine, Nursing and Health sciences, Monash University, Melbourne, Australia*

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Introduction Although only 20% of people with Alcohol Use Disorder (AUD) develop liver fibrosis/cirrhosis, those affected experience high morbidity and mortality. Better strategies are required to identify cases of advanced liver fibrosis amongst people with AUD. The Enhanced Liver Fibrosis (ELF) test has been used to good effect in NAFLD to identify people with liver disease. There has been concern that recent alcohol intake may elevate ELF scores, confounding diagnostic performance. We have investigated the relationship between ELF scores and alcohol consumption in people with AUD referred to a hospital-based alcohol specialist nurse (ASN).

Method Prospective service evaluation of liver fibrosis in consecutive patients referred to the ASN at the Royal Free Hospital from Nov' 2018-Dec' 2019. Patients were excluded if they were already known to have liver disease. Five ml of blood was collected and analysed for ELF score on an Advia Centuar. Data recorded included demographics, blood test and imaging results and self-reported alcohol history. Data were analysed using SPSS.

Results We included 100 patients (69% male, mean age 53.15 ± 14.3). Average BMI was 26.52 (± 5.94) and 85% were current or past smokers. Median alcohol intake was 140 units/week (IQR 79.1–280), with duration of excess alcohol of 15 years (IQR 10–29). The vast majority (97/100, 97%) were drinking alcohol within the last month prior to ELF test. Liver function tests were abnormal in 64/96 (66.7%) patients. ELF scores ranged from 6.87 to 13.78, median 9.66 (IQR 8.94–10.6). Of the total cohort, 29/100 (29%) had an ELF score of $\geq$10.5 indicating advanced fibrosis, and 14/100 (14%) had ELF scores $\geq$11.3 indicating cirrhosis. ELF score increased with age ($p = 0.037$). Alcohol intake was not